P.O. Box 14192, Lexington, KY 40512-1192
Telephone: 800-638-4228 Facsimile: 859-264-4384 Email: myclaimdocs@sedgwick.com

Attending Physician Statement

To be completed by physician

Patient's Name: **Date of Birth:**

Claim Number: **Medical Due Date:**

1. Objective findings: HT: WT: BP: TEMP: PULSE: RESP: ____________
2. Patient's Complaints: ____
____
____
____
3. Your Diagnosis: (list all disabling diagnoses including all ICD codes)
Primary: ICD Code: ______________ Description:______________________________
Secondary: ICD Code: ______________ Description:______________________________
4. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. ____
____
____
____
5. When was patient first diagnosed with this condition? _____/_____/_____
List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
				Yes ☐ No ☐	Yes ☐ No ☐	_____/_____/_____
				Yes ☐ No ☐	Yes ☐ No ☐	_____/_____/_____
				Yes ☐ No ☐	Yes ☐ No ☐	_____/_____/_____
				Yes ☐ No ☐	Yes ☐ No ☐	_____/_____/_____

6. Is this condition the result of an injury? Yes ☐ No ☐ Is this condition work related? Yes ☐ No ☐ If yes, provide date and description of event: ____
____
____
List all co-morbid conditions:____
____
7. If patient is pregnant, indicate estimated date of delivery _____/_____/_____
8. Is a C-Section planned? Yes ☐ No ☐ If yes, date scheduled: _____/_____/_____
9. Give all dates of treatments by you during this period of disability; also indicate date of follow up visit: ______________
____
____
10. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):
____
____
____

11. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? Yes ☐ No ☐

 If Yes: ☐ Emergency Room visit ☐ Hospitalization ☐ 23 hour admission

 Name and address of hospital or facility ______________________________

 ____

 Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

 Indicate treatment provided: ______________________________

12. Has any surgical procedure related to current disability been performed or is any anticipated? Yes ☐ No ☐

 List the name of the procedure: ______________________________

 CPT code: ______________________________

 Date of procedure: _____/_____/_____

13. Has patient been referred to other physician(s)/specialist? Yes ☐ No ☐ If yes, provide physician name, specialty, and telephone number. ______________________________

 ____

14. List specific functional limitations of Activities of Daily Living (ADL's): ______________________________

 ____

 ____

 ____

15. Has patient been given any driving restrictions for this disability period? Yes ☐ No ☐

 If yes please describe: ______________________________

16. Based on your personal knowledge and treatment, how long has the patient been totally disabled by this sickness and prevented from working? From _____/_____/_____ to and including _____/_____/_____

17. Has the patient recovered sufficiently to return to work? Yes ☐ No ☐

 If yes, give the date the patient was able to return to work _____/_____/_____

 If no, in your opinion when, may work be resumed? (please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months, the total duration of disability. _____/_____/_____

 ____

18. Has the patient recovered sufficiently to return to restricted work? Yes ☐ No ☐

 If yes, indicate date restrictions begin: _____/_____/_____ date restrictions end: _____/_____/_____

 Restriction (s) required: ______________________________

 ____

 ____

Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: ______________ Physician Printed Name: ______________________________

Fax Number: ______________ Physician Specialty: ______________________________

Date Completed: ______________ Physician Signature: ______________________________